

STATE OF NEW JERSEY  
DEPARTMENT OF THE TREASURY  
DIVISION OF PENSIONS AND BENEFITS  
PO BOX 299  
TRENTON, NJ 08625-0299

**STATE HEALTH BENEFITS PROGRAM COVERAGE  
WAIVER/REINSTATEMENT**

**Part 1:** To be completed by the employee. Please print.

1. Name \_\_\_\_\_ SS# \_\_\_\_\_

Check one box below.

☐ **Waiver of Coverage**

In accordance with Chapter 259, P.L. 1995 (municipalities), or Chapter 189, P.L. 2001 (municipal authorities), I have agreed to waive the State Health Benefits coverage to which I am entitled because I am covered under my spouse's health coverage.

Name of spouse's health plan \_\_\_\_\_

In place of health benefits, my employer will pay me the amount shown in Part 2 below. I understand that I may resume State Health Benefits Program coverage when I am no longer covered by my spouse.

☐ **Reinstatement of Coverage**

I previously waived State Health Benefits coverage since I had health coverage through my spouse. As of \_\_\_\_\_, I am no longer covered by my spouse's health plan, so I request reinstatement  
(date)  
of the State Health Benefits coverage.

**Employee's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Part 2:** To be completed by the employer. Check one box below.

☐ We will pay the above employee \$\_\_\_\_\_ every \_\_\_\_\_ in place of providing State Health Benefits coverage. We understand that this payment may not be more than 50% of the amount saved by the municipality because of the waiver.

☐ We request reinstatement of this employee's State Health Benefits coverage.

**A completed State Health Benefits Application must be attached to either a waiver or a reinstatement.** If the application for waiver is received by the Health Benefits Bureau by the 5th of the month, the change will take place on the first of the following month. The reinstatement application must be filed within 60 days of spousal health coverage loss. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed and the reinstatement is received by the Health Benefits Bureau by the 5th of the month, it will be processed in a timely manner, so the change will take place on the first of the following month.

Employer Name \_\_\_\_\_ Location # 92- \_\_\_\_\_

Signature of Certifying Officer \_\_\_\_\_ Date \_\_\_\_\_